www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

VISION SCREENING REPORT

MED 4 (09/09/05)

Purpose: Use this form to provide DMV with vision screening information from an ophthalmologist or optometrist. Vision screening is required as part of the driver's license application process.

Instructions: Have your ophthalmologist/optometrist print or type required information in the spaces provided and submit it to any DMV, at any local customer service center.

CUSTOMER INFORMATION

If you change either your residence/home address or mailing address to a non-Virginia address, your driver license or photo identification (ID) card may be canceled.	LICENSE APPLICATION DATE (mm/dd/yyyy)
FULL LEGAL NAME (last) (first) (mi) (suffix)	DMV CUSTOMER NUMBER
RESIDENCE/HOME ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS. (note: the address provided will be on DMV's system as your current mailing address.)	

CITY	STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE
MAILING ADDRESS (if different from above)			
CITY	STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER ( )

DATE OF BIRTH (mm/dd/yyyy)	GENDER ☐ MALE ☐ FEMALE	WEIGHT	HEIGHT FT IN	EYE COLOR	HAIR COLOR

TO BE COMPLETED BY AN OPHTHALMOLOGIST/OPTOMETRIST.
The examination should be conducted without the aid of a bioptic telescopic device.

CUSTOMER NAME	DRIVER LICENSE OR SOCIAL SECURITY NUMBER
WHEN WAS THE PATIENT LAST EXAMINED BY YOU?	MAY THE DEPARTMENT OF MOTOR VEHICLES RELEASE THE INFORMATION YOU PROVIDE ON THIS FORM TO THE PATIENT? ☐ YES ☐ NO

	Right Eye	Left Eye	Both Eyes		Right Eye	Left Eye	Both Eyes
Visual Acuity Without Corrective Lenses	20	20	20	Horizontal Vision Field	º	º	º
Visual Acuity With Corrective Lenses	20	20	20	If One Eye Only	Temporal º	Nasal º	

Quadrant Defect ☐ OD ☐ OS ☐ OU Hemianopic Defect ☐ OD ☐ OS ☐ OU Central Scotoma Defect ☐ OD ☐ OS ☐ OU

Constricted Fields _____º Remaining OD _____º OS _____º Patient's legally blind ☐ OD ☐ OS ☐ OU

Does the patient have any visual defects/visual field loss that would affect the safe operation of a motor vehicle? ☐ Yes If yes, explain ☐ No

Is this patient's condition likely to progress over the next 5 years? ☐ Yes ☐ No If yes, explain

In your opinion, is the patient capable of safely operating a motor vehicle? ☐ Yes ☐ No If no, explain

In your opinion, is the patient capable of safely operating a commercial motor vehicle? ☐ Yes ☐ No If no, explain

Ophthalmologist/Optometrist Recommendations: ☐ Daylight Driving Only ☐ Wear Corrective Lenses While Driving

Applicant should submit periodic vision examination results to DMV every _____. (mos – yrs)

OPHTHALMOLOGIST/OPTOMETRIST LICENSE INFORMATION
Required to process this application

OPHTHALMOLOGIST/OPTOMETRIST NAME	OPHTHALMOLOGIST/OPTOMETRIST SIGNATURE	DATE (mm/dd/yyyy)
OPHTHALMOLOGIST/OPTOMETRIST LICENSE NUMBER	OPHTHALMOLOGIST/OPTOMETRIST LICENSE EXPIRATION DATE (mm/dd/yyyy)	STATE ISSUING LICENSE TO PRACTICE
CHECK BOX TO INDICATE LICENSE TYPE ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST	TELEPHONE NUMBER ( )	FAX NUMBER ( )

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

ADDITIONAL VISION SCREENING INFORMATION FOR A DRIVERS LICENSE APPLICATION

All requested driver visual information must be provided before the Department of Motor Vehicles (DMV) will review a driver's license application.

VISION SCREENING AND EXAMINATION INFORMATION

Applicants failing DMV's vision screening must provide the results of an ophthalmologist's or optometrist's examination before DMV will review the driver's license application.

The ophthalmologist's/optometrist's examination is to be conducted without the use of a telescopic device.

If an ophthalmologist's or optometrist's examination is required for license consideration, the examination must be conducted within 90 days prior to the DMV license application date on the front of this form.

FAILED VISION EXAMINATIONS

DMV is required by statute (§ 46.2-221) to report to the Department for the Visually Handicapped and the Department of Rehabilitative Services all persons refused a license because of failed vision screening.

MEDICAL REVIEW INFORMATION

The decision regarding your driving privilege will be based on medical, vision and other related information received, driver license test results, as well as DMV's medical review policies and guidelines as established by the DMV Medical Advisory Board.

The Code of Virginia § 46.2-322 provides that if you submit a written request, DMV will furnish the reasons for the examination, including the identity of anyone who supplied information regarding your fitness to drive a motor vehicle. However, this law states that DMV cannot provide the information if the source is a relative or licensed medical professional treating you.

MINIMUM VISION REQUIREMENTS

Minimum requirements may be met with or without corrective lenses. If you need to wear glasses or contact lenses to pass the vision screening, you must wear them when you drive. Your license will show this restriction.

DRIVER'S LICENSE		
	Visual Acuity	**Horizontal Vision**
No Restrictions	20/40 or better in one or both eyes	100 degrees or better
Driver Restricted to Daylight Driving	20/70 or better in one or both eyes	70 degrees or better 40 degrees or both temporal 30 degrees or both nasal

COMMERCIAL DRIVER'S LICENSE		
	Visual Acuity	**Horizontal Vision**
No Restrictions	20/40 or better in each eye	140 degrees or better
Driver with one eye	20/40 or better in one	120 degrees or better